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DEPARTMENT OF HEALTH AND SENIOR SERVICES
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Acting Commissioner

January 28, 2005

TO: Hospital CEOs

FROM: Marilyn Dahl
Deputy Commissioner, Health Care Quality and Oversight

RE: Revised Hospital Patient Safety Act Reporting Timeframes

In December 2004, the Department of Health and Senior Services (Department) sent you correspondence summarizing the Patient Safety Act interim mandatory reporting process to be implemented for general hospitals. The new procedures outlined in the December correspondence, accompanying forms and instructions replaces the existing reporting process articulated in a May 5, 2003 memorandum from the Department. The new reporting process goes into effect for general hospitals on February 1st. Based on discussions with industry representatives, the Department is making some changes, primarily to expand the timeframe for reporting.

The December 7, 2004 memorandum noted the types of events subject to mandatory reporting, documented how the reporting would occur, specified the timeframes for reporting and indicated the follow-up actions required of hospitals and the Department. The December correspondence provided that a hospital was required to notify the Department within two (2) business days of discovery of the event, but no later than five (5) days after the occurrence of the event. That correspondence further provided that, in the case of objects erroneously retained in the body after surgery, the hospital shall notify the Department no later than two business days after the discovery of the event.

Effective February 1st, the amended reporting process requires a hospital to notify the Department of a serious preventable adverse event no later than five (5) business days after the facility discovers, or should have discovered, the occurrence of the event.

The Department has also modified the reporting requirements for objects erroneously retained in a patient after surgery, to acknowledge that the discovery may be made by a facility other than the facility where the event occurred. In such cases, the facility that discovers the event shall be responsible for notifying the Department in a timely manner after discovery, but shall have no further responsibility for performing a

root cause analysis or other follow-up related to the event. Additionally, the facility providing notification to the Department must also identify the facility where the retained object event occurred, if that information is known.

The time frame for submission of a root cause analysis has not changed. The hospital is still required to submit the root cause analysis within 45 days following the initial report to the Department.

As noted above, general hospitals are required to implement the new reporting process on February 1, 2005. Please be aware that the Department will post any future updates or changes to the reporting requirements at http://www.nj.gov/health/hcqo/ps.

If you have any questions concerning the reporting requirements, please direct them to Frances Prestianni, Ph.D. , Program Manager, Health Care Quality Assessment,at 609-530-7473.

Thank you for your support as we begin implementing the Patient Safety Act.

C: Jay Jimenez, Chief of Staff
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New Jersey Hospital Association
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